STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

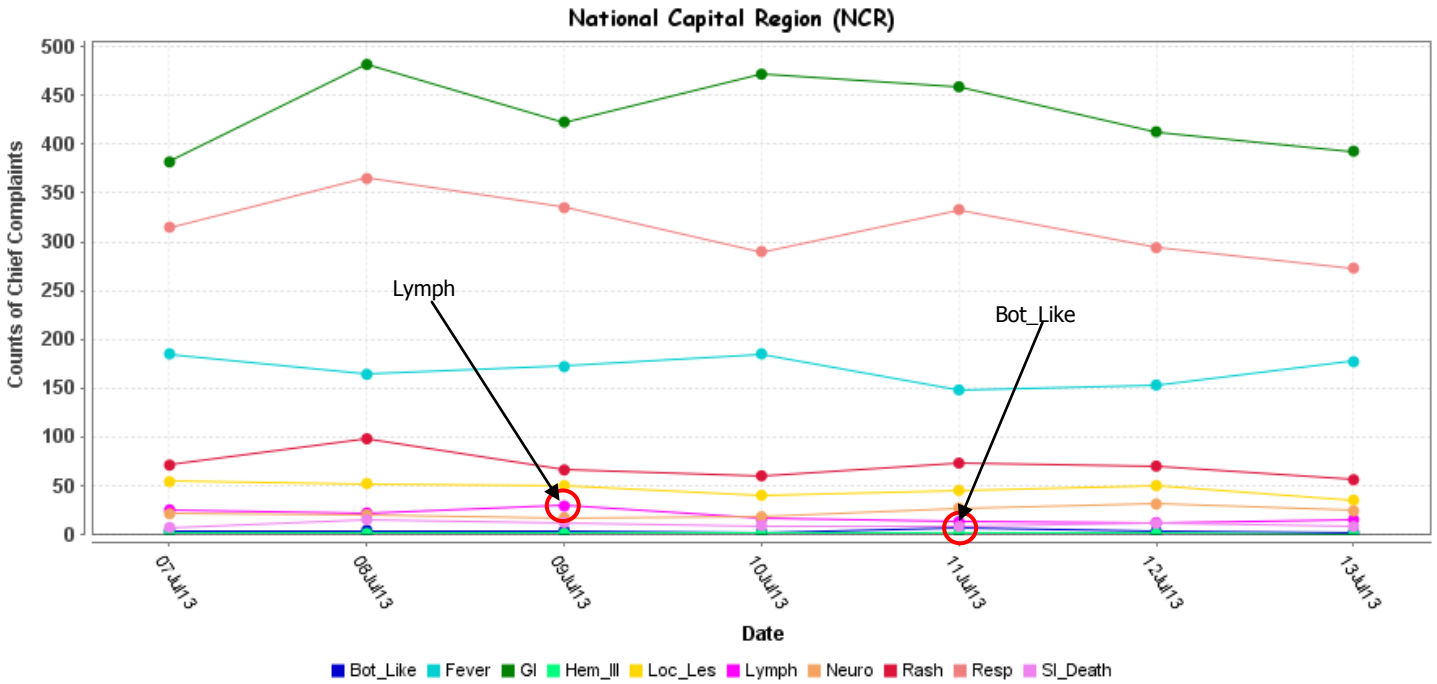
July 19, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:28
Reporting for the week ending 07/13/13 (MMWR Week #28)

CURRENT HOMELAND SECURITY THREAT LEVELS

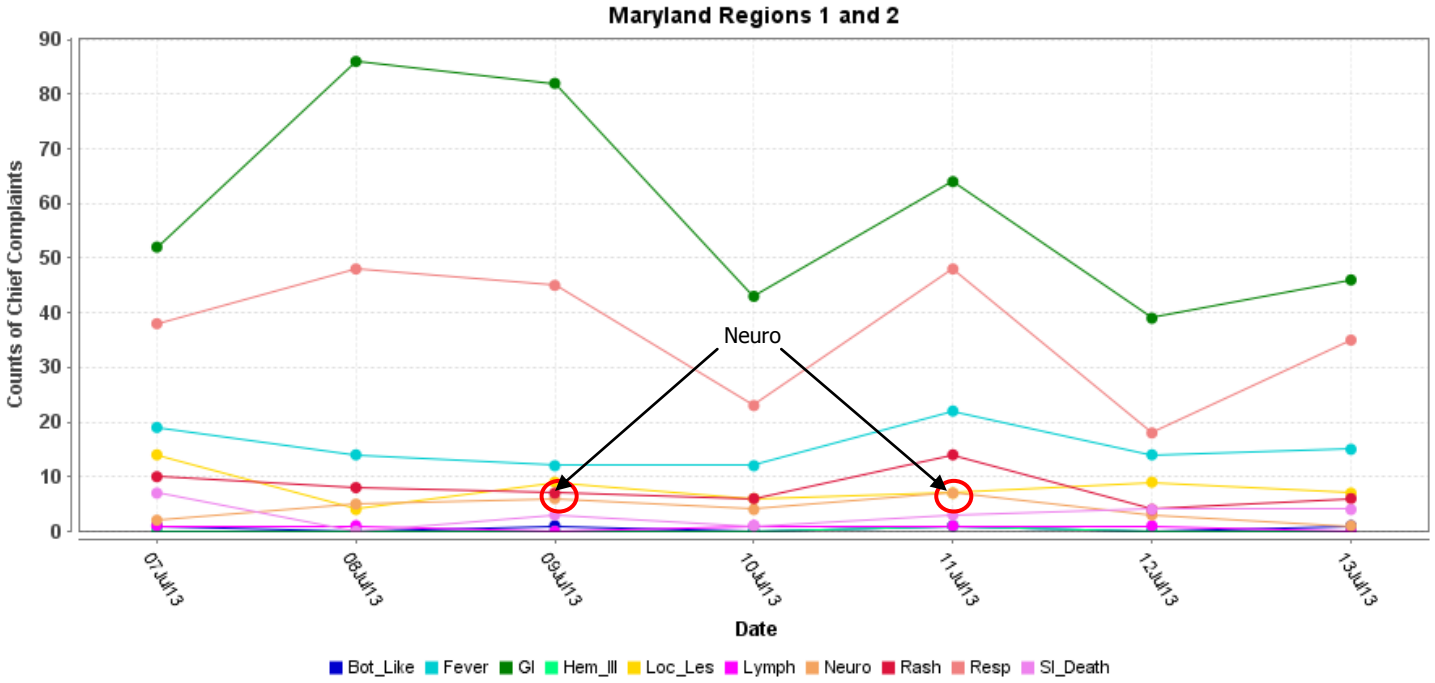
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

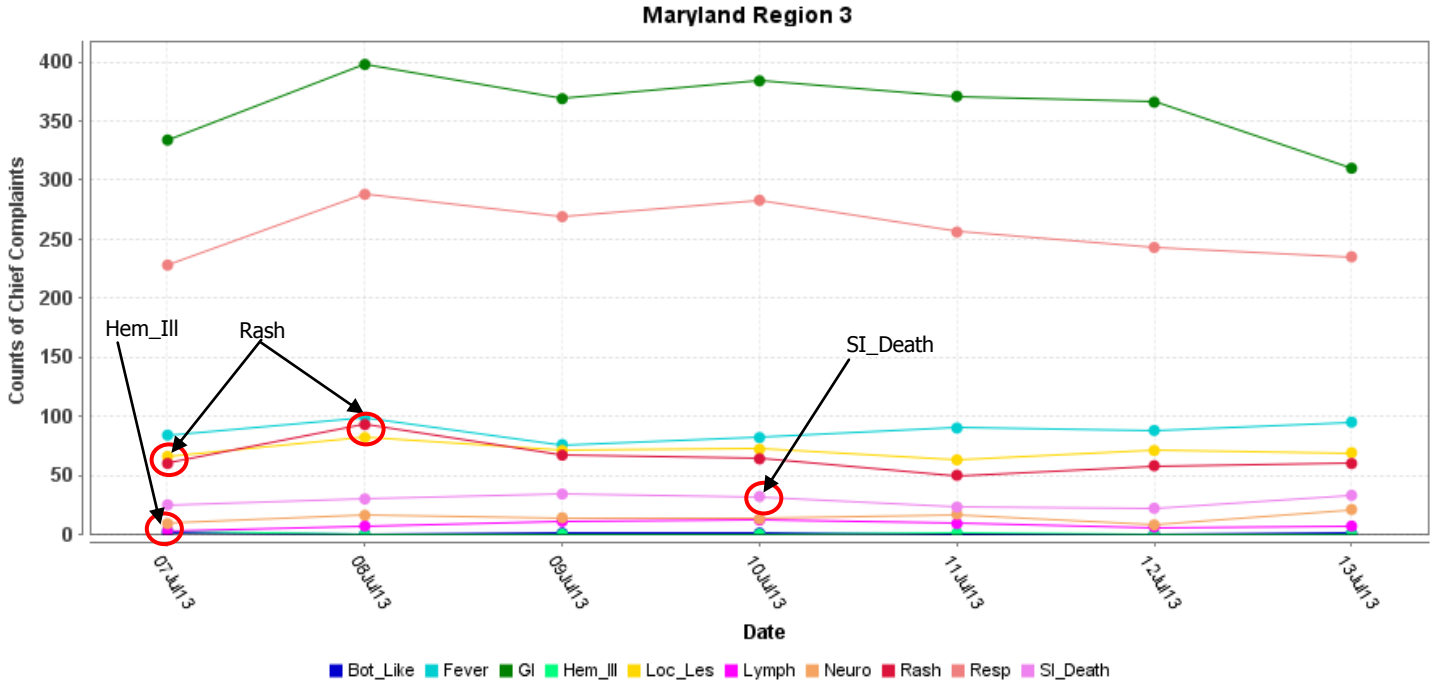


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

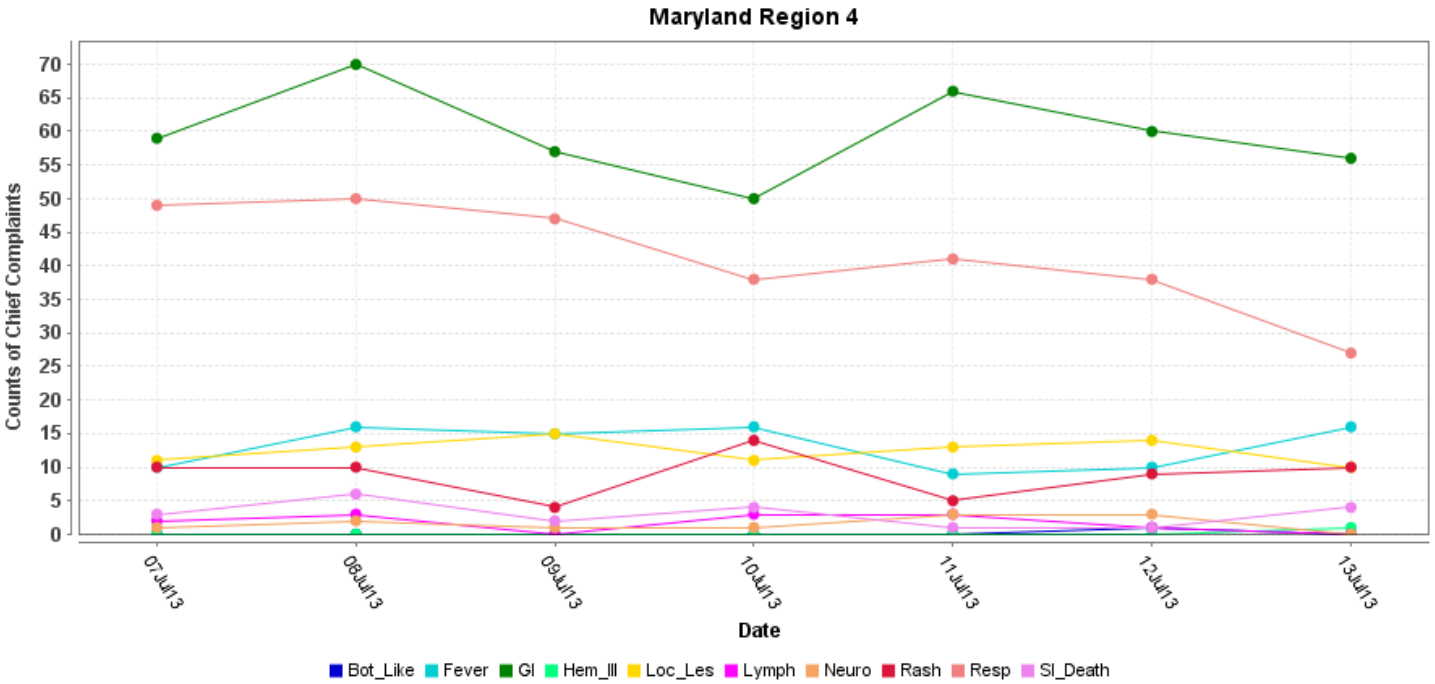
MARYLAND ESSENCE:



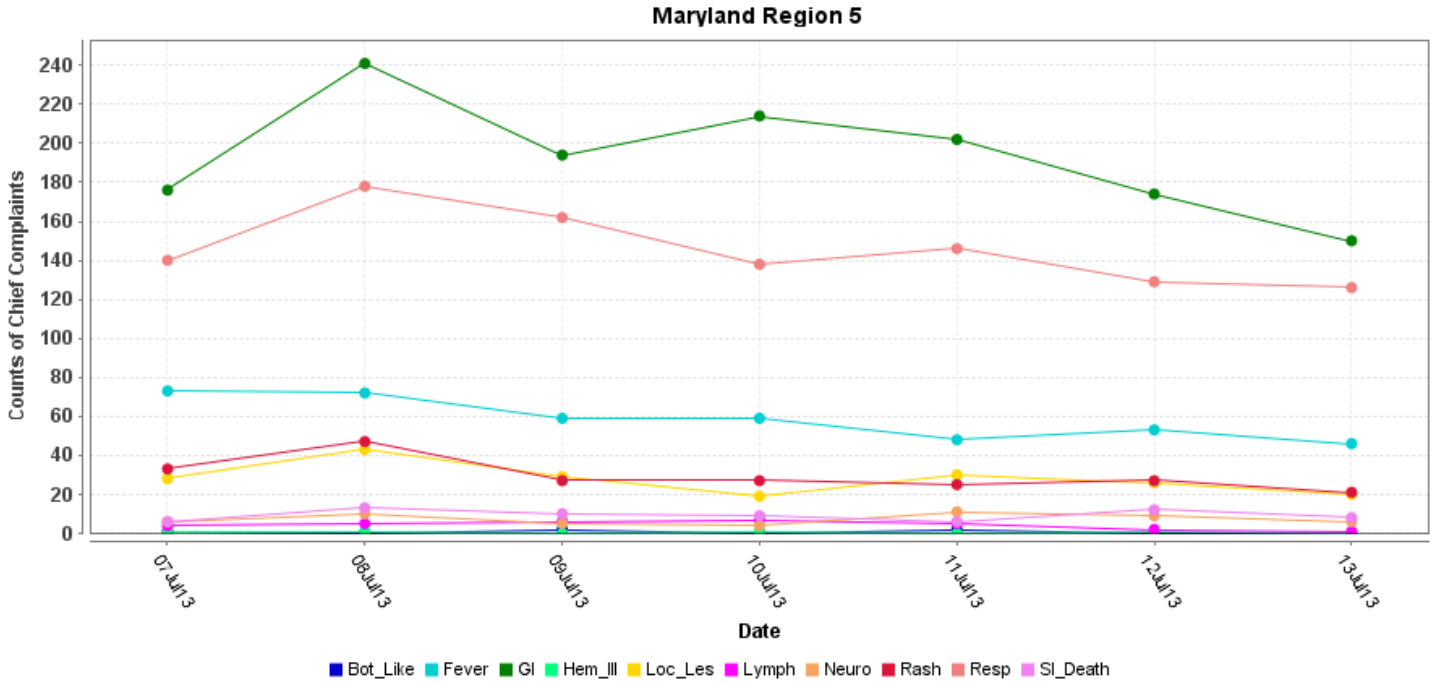
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



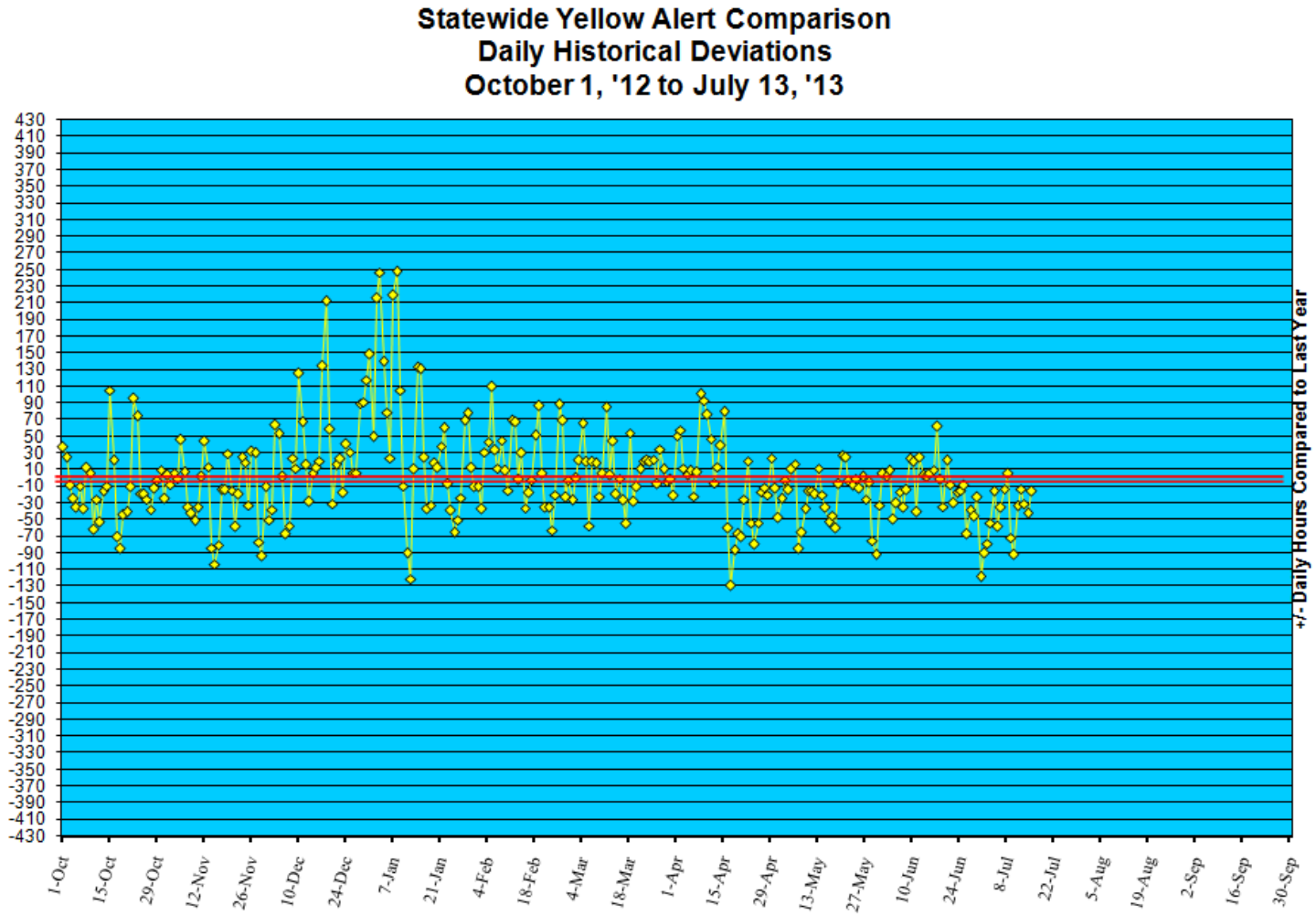
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in June 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (July 7 - July 13, 2013):	2	0
Prior week (June 30- July 6, 2013):	10	0
Week#27, 2012 (July 9 – July 15, 2012):	12	0

3 outbreaks were reported to DHMH during MMWR Week 28 (July 7 – July 13, 2013)

2 Gastroenteritis Outbreak
1 outbreak of GASTROENTERITIS in a Nursing Home
1 outbreak of GASTROENTERITIS associated with a Camp

1 Respiratory Illness Outbreak
1 outbreak of PNEUMONIA in a Nursing Home

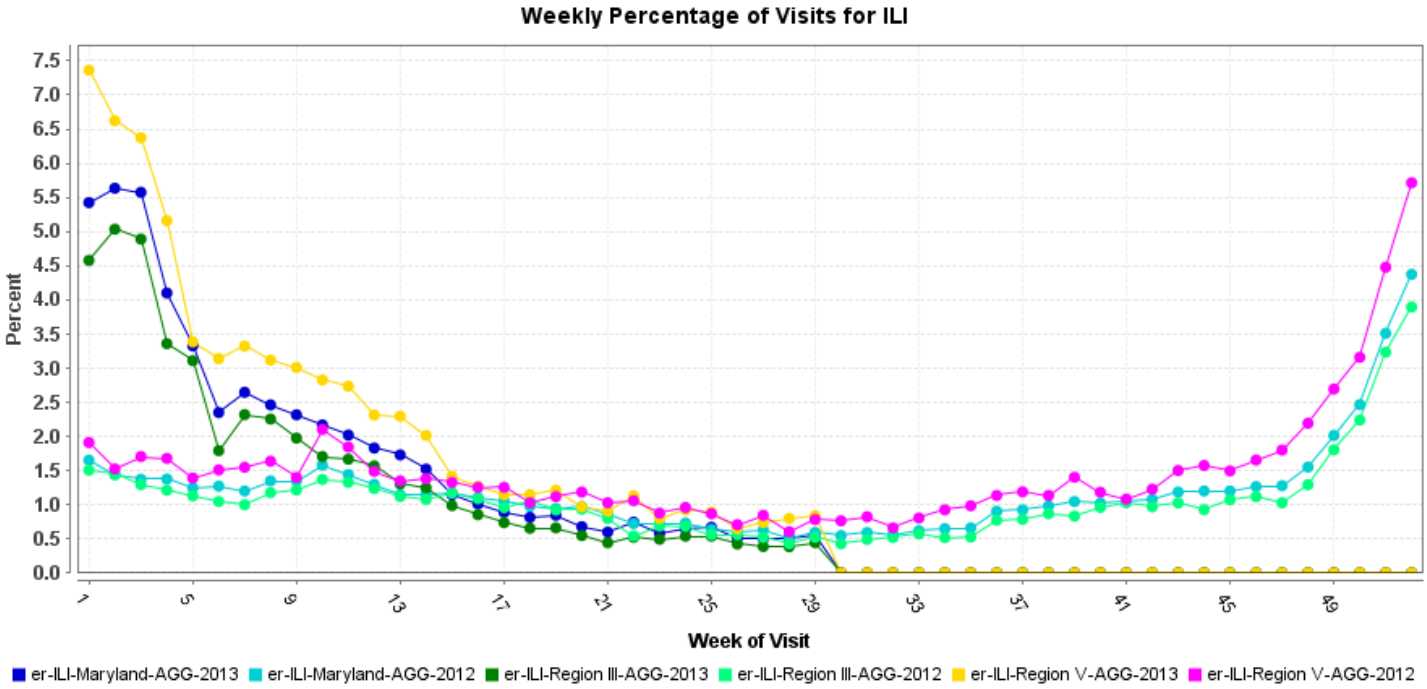
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

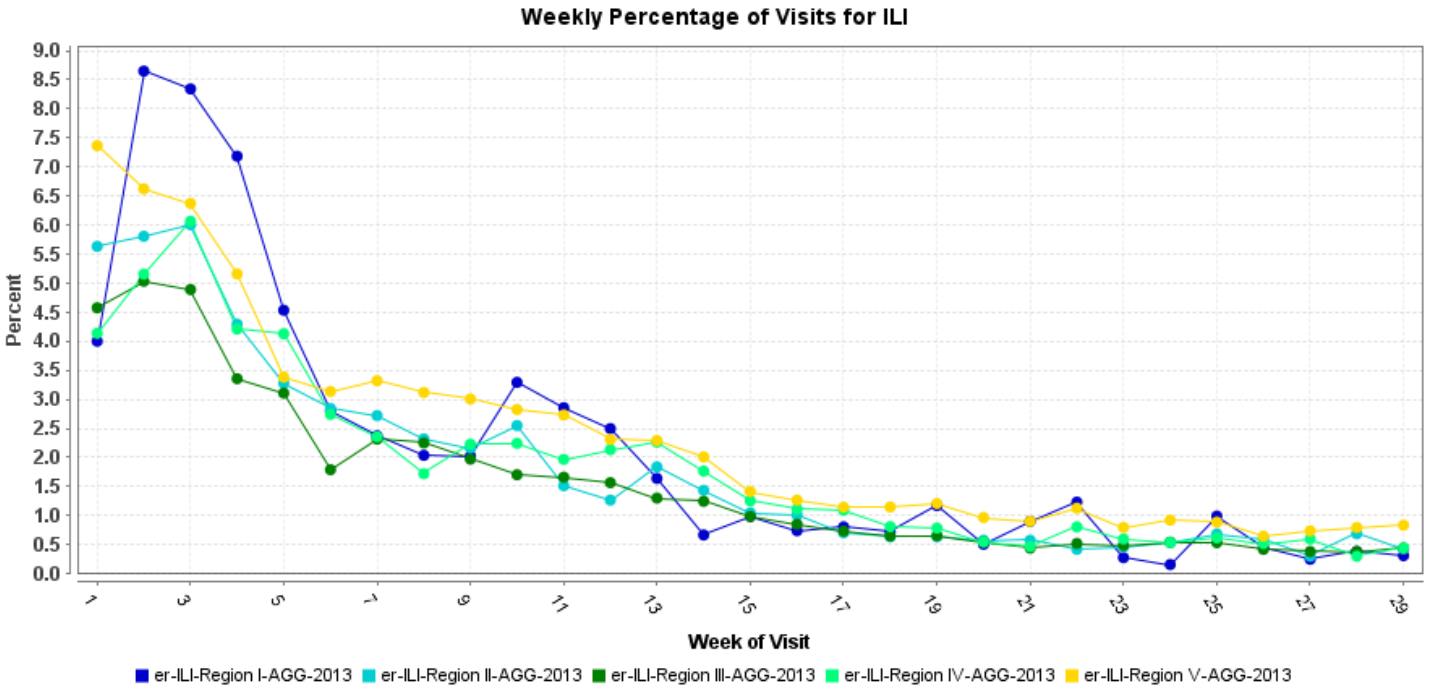
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



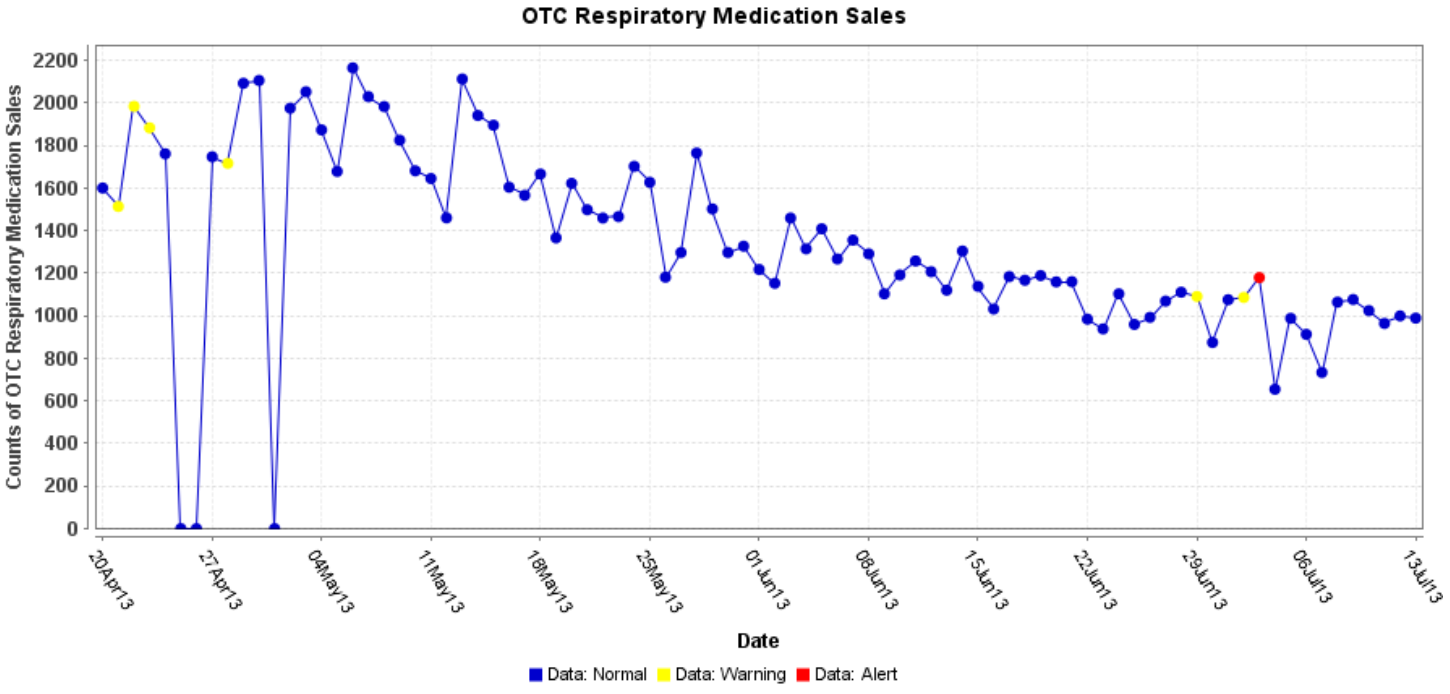
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of July 5, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 633, of which 377 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 60%.

AVIAN INFLUENZA, HUMAN (CAMBODIA): 12 July 2013, A 3-year-old boy from Cambodia's eastern Prey Veng province has been confirmed positive for avian A (H5N1) influenza virus infection, bringing the number of cases to 14 so far this year [2013], a joint statement by the World Health Organization (WHO) and Cambodian Health Ministry said Friday [12 Jul 2013]. Only 5 cases out of the 14 cases this year [2013] survived. The 14th victim was confirmed positive for H5N1 on Wednesday [10 Jul 2013], the statement said, adding that the boy was admitted to the Kantha Bopha Hospital with fever, dyspnea and cough Monday [8 Jul 2013]. "At the hospital, he was treated with Tamiflu and is currently in stable condition," it said. "There were recent deaths among poultry in the village and the boy was likely to [have been] exposed to sick and dead poultry before he became sick," it added. Avian influenza H5N1 remained a serious threat to the health of all Cambodians, Health Minister Mam Bunheng said. "Children also seem to be most vulnerable and are at high risk because they like to play where poultry are found," he said in the statement. "I urge parents and guardians to keep children away from sick or dead poultry and make sure children wash their hands with soap and water after any contact with poultry." H5N1 influenza is a flu that normally spreads between sick poultry, but it can sometimes spread from poultry to humans, the statement said, adding that it is a very serious disease that requires hospitalization. Cambodia sees the worst outbreak of the virus this year [2013] since the disease was 1st identified in 2004. To date [12 Jul 2013], the country has recorded 35 human cases of the virus, killing 28 people. Since 2003, there have been 633 laboratory-confirmed human cases of H5N1 virus globally with 376 related deaths, the statement said.

NATIONAL DISEASE REPORTS*

CYCLOSPORIASIS (USA): 13 July 2013, Confirmed cases of a rare food-borne illness have doubled in Iowa over 4 days and increased dramatically in Nebraska, with public health agencies scrambling Friday [12 Jul 2013] to figure out the source. The outbreak of cyclosporiasis has sickened 45 Iowans, the Iowa Department of Public Health said Friday [12 Jul 2013]. On Monday [8 Jul 2013] the department had identified 22 cases. The increase may be due to more people hearing about it and getting tested, said Dr. Patricia Quinlisk, the state's epidemiologist and medical director for Iowa's public health agency. "We're not ready to say it's absolutely for sure; things are pointing more toward a vegetable rather than a fruit, but we're still looking at everything," Quinlisk said of the source. She suggests that people wash fruits and vegetables thoroughly to reduce the risk of illness. In Nebraska, the state had documented 35 cases as of Friday [12 Jul 2013], mostly in Douglas County on the eastern edge bordering Iowa. The illness is most commonly contracted by eating food or drinking water contaminated with human or animal feces containing the cyclospora parasite. Since the parasite needs several days -- sometimes weeks -- to become infectious, it is not passed directly from person to person. It typically takes a week to get sick after ingesting the parasite. Symptoms of cyclosporiasis include watery diarrhea, loss of appetite, weight loss, stomach cramps, nausea, body aches and fatigue. If untreated, it can cause frequent, sometimes explosive, bowel movements that lasts an average of 57 days if untreated. Most of the 45 Iowa residents became sick in mid to late June [2013] and at least one person has been hospitalized. Many people report still being ill with diarrhea and some have seen the symptoms ease but then return. The US Centers for Disease Control and Prevention said relapses are not unusual. The recommended treatment is a combination of 2 antibiotics, which shortens the duration of the illness significantly, said Nebraska state epidemiologist Dr. Thomas Safranek. People who have diarrhea should also rest and drink plenty of fluids. Quinlisk said investigators are trying to determine whether the confirmed illnesses were the result of a batch of contaminated produce and if new batches being delivered are continuing the exposure. "Right now, it's hard to say, but most people coming in now did get sick a while ago, not a couple of days ago," she said. "We don't want to say yet whether exposures continue. We don't know for sure." Safranek said all of Nebraska's cases also involve people who became ill in June [2013], which suggests whatever contaminated food that caused it may have worked its way through the system. "If we start getting people who have new onset dates here in July [2013], that's going to be a cause for concern. There's a specter of hope that it may have passed through the system -- whatever it was -- and there's no ongoing risk," he said. Quinlisk and Safranek believe the illnesses may be traced to a food product distributed primarily to Iowa and Nebraska. While 3 other states are investigating cases, Quinlisk said no definite link has been established. The illness is rare in Iowa with typically just 1 to 2 cases reported a year, usually involving people who acquired the illness while traveling, Quinlisk said. The illness also is rare in Nebraska with no cases reported in the last 4 years and only one case in 2007 and one in 2008. Iowa's Linn County has the largest concentration of cases with 21. Fayette, Polk, and O'Brien counties each had 3 cases; and Dallas, Mills, Webster, and Des Moines counties each had 2 cases confirmed. Another 7 counties each reported one confirmed case. Data from the CDC indicates it is not a widely occurring illness nationally. In 2011, the most recent year for which national data is available, the agency documented 151 cases. Outbreaks in recent years have been traced to blackberries, raspberries, strawberries, basil, arugula, vegetable-based salads, pasta salad, tuna salad, green beans, peas, and fruit salad. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

HANTAVIRUS (ARIZONA): 13 July 2013, Authorities say a 2nd Coconino County resident has been diagnosed with hantavirus, but the woman is recovering. Health officials said Wednesday [10 Jul 2013] that the woman lives in the county's southwestern area but didn't release her name, age, or city where she resides. County Public Health Services District officials say they're investigating where the woman contracted [a] hantavirus, which is spread by infected rodent droppings. Authorities say a Flagstaff [Coconino County] woman died last month [June 2013] from complications of hantavirus. Her name wasn't released. [Sin Nombre] hantavirus is transmitted to people that come into contact with or breathe infected urine, droppings, and/or saliva of wild mice, primarily deer mice [Peromyscus maniculatus]. The virus isn't spread from person to person. Health officials say there have now been 23 confirmed hantavirus cases in Arizona since 2006 and 11 of those victims died. (Hantavirus is listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS (USA): 11 July 2013, The Alabama Department of Public Health is investigating a foodborne outbreak that has affected at least 36 people who ate a meal at a funeral. Around noon on Sat 6 Jul 2013, people attending a funeral at Eastern Star Baptist Church in York, Alabama, ate an undisclosed dish that made them sick. More than 100 people are reported to have attended this funeral. Initial reports indicate that at least 30 have been hospitalized, with some in serious condition. The ongoing investigation has involved hospitals in at least 9 states. These states currently include Alabama, California, Florida, Georgia, Illinois, Kansas, Michigan, Missouri and Oklahoma. Preliminary tests at the Alabama Bureau of Clinical Laboratories are positive for Salmonella, and additional tests are pending. ADPH's investigation began on 8 Jul 2013 after a report from a local hospital that 25 people had been seeking emergency room care late on 6 Jul 2013 and 7 Jul 2013 -- and 7 with symptoms of fever, diarrhea, nausea and vomiting. "If you attended this event and are ill, please contact your physician," advised Dr. Mary McIntyre, Assistant State Health Officer for Disease Control and Prevention. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SHIGELLOSIS (USA): 11 July 2013, Today [9 Jul 2013] the Rhode Island Department of Health reported that stool specimens from 19 of the patients who became ill with diarrheal illness after swimming at Spring Lake Beach [Providence county, Rhode Island] on 4 Jul 2013 are positive for the bacterium Shigella sonnei. The department began investigating the outbreak of gastrointestinal illness associated with the public swimming area on 6 Jul 2013. To date, 92 individuals have been identified as ill and 16 have been hospitalized with bloody diarrhea. All swam at Spring Lake Beach in Burrillville on 4 Jul 2013. The department believes that the shigellosis came from fecal contamination of the water on that date. Approximately 80 percent of the people who are ill are children under 18 years of age. Hospitalized cases at Hasbro Children's Hospital are recovering well and no severe illness has been reported in adults. "Anyone who recently swam at Spring Lake and is experiencing diarrhea, abdominal pain, fever, or vomiting should see his or her doctor," said Michael Fine, MD, Director of Health. The Health Department is reopening Spring Lake Beach for swimming beginning tomorrow [10 Jul 2013], as water test results from Sunday [7 Jul 2013] and Monday [8 Jul 2013] show no evidence of fecal coliform bacteria. In addition, Shigella does not survive outside the body for long periods and does not survive in warm temperatures. The water temperature in Spring Lake has been high over the last several days. "Town officials from Burrillville were extremely helpful throughout this investigation," said Dr. Fine. "I thank them for their cooperation and assistance." All licensed beaches in Rhode Island are now open for swimming. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

CHOLERA (HAITI): 13 July 2013, The number of cases of cholera in Haiti registered between May and June 2013 increased by 1356 patients, and since the disease appeared in the country, it has caused the death of 8136 people. The Department of Public Health and Population indicated in its last epidemiological bulletin that the number of cases increased from 3357 in May 2013 to 4713 in June 2013, for an increment of 40 percent with regard to previous months. According to the office, most cases of those affected by the infection were registered in 4 departments, including Port-au-Prince [in Ouest department], the capital of the country. The situation was attributed to the current season of rains and to difficulties in achieving an acceptable level of clean-up and greater awareness of measures of hygiene. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (CUBA): 13 July 2013, Radio Marti reports that in recent weeks, dozens of people in several municipalities in the province of Matanzas have been admitted to health facilities or quarantined at home for diarrhea and other symptoms typical of cholera. Opponents and independent journalists quoted by the broadcaster said the outbreak is affecting at least 5 municipalities of the province: Cardenas, Union de Reyes, Jovellanos, Pedro Betancourt, and Marti. Independent journalist Oscar Sanchez Madan said 2 doctors, one them a gastroenterologist, who requested anonymity, confirmed some of the patients have cholera. The doctors said they have been instructed not to inform the population and that the rest of the cases have diarrhea caused by other pathogens. The doctors work in Cardenas, where many people who work in the nearby tourist resort of Varadero live. According to Sanchez Madan, despite the secrecy with which the matter is being handled, sanitary measures that have already been seen in other parts of the country where cases of cholera have been detected, are being implemented in the city. The delegate of the Patriotic Union of Cuba in Cardenas, Eduardo Marcos Pacheco Ortiz, described an atmosphere of nervousness among the people, who try not to eat anything on the street. He said that although local authorities refrain from mentioning cholera, everyone knows what it is because of the measures being implemented, such as urging people to wash their hands, dip their shoes in chlorinated water when entering public places, and enhance the repair of leaks in sewers. In several of the affected areas authorities have closed cafeterias and banned self-employed persons from selling refreshments. Pacheco estimated at 30 the number of cases in Cardenas. An activist said in her Twitter account that about 33 people had been admitted to the local hospital. According to Pacheco, patients who arrive at the Julio Aristegui Villamil hospital in serious condition are hospitalized and the others are sent home and quarantined. The wife of Juan Francisco Sigler Amaya, leader of the Alternative Action Movement, reported from Pedro Betancourt [municipality] that on Thu 4 Jul 2013, many people flocked to the local polyclinic with diarrhea. Another member of Alternative Action Movement, said that last week the Community Services (including garbage collection) workers of Pedro Betancourt were transferred to Jovellanos, just 16 kilometers [10 mi] away, which was seen as an indication that the outbreak may have started earlier in the nearby locality. Since the emergence of cholera in Manzanillo, Granma, in 2012, the disease has not been eradicated and cases have been reported in almost all provinces of the country. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

PLAGUE (RUSSIA): 11 July 2013, An outbreak of plague was found in the Kulinsky district of the republic [Russian federal subject] of Dagestan. As long as people are highly susceptible to the disease, immunizations will be conducted for the population to avoid mass infection. Restrictive measures will be taken on the territory of nearby villages. Plague is a deadly infectious disease that is caused by Yersinia pestis, named after the French-Swiss bacteriologist Alexandre Yersin. Primarily carried by rodents (most notably rats) and spread to humans via fleas, the disease is notorious throughout history, due to the unrivaled scale of death and devastation it brought. Until June 2007, plague was one of the 3 epidemic diseases specifically reportable to the World Health Organization (the other 2 being cholera and yellow fever). (Plague is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

MERS-COV (EASTERN MEDITERRANEAN): 11 July 2013, The Ministry of Health (MoH) in Saudi Arabia has announced an additional laboratory-confirmed case of Middle East respiratory syndrome coronavirus (MERS-CoV) infection in the country. The patient is a 66-year-old man from Asir region with an underlying health condition. He is currently in critical but stable condition. In addition, a Qatari patient earlier confirmed with MERS-CoV infection, who was being treated in the United Kingdom, died on [28 Jun 2013]. Globally, from September 2012 to date, WHO has been informed of a total of 81 laboratory-confirmed cases of infection with MERS-CoV, including 45 deaths. Based on the current situation and available information, WHO encourages

all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns. Health care providers are advised to maintain vigilance. Recent travelers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Specimens from patients' lower respiratory tracts should be obtained for diagnosis where possible. Clinicians are reminded that MERS-CoV infection should be considered even with atypical signs and symptoms, such as diarrhea, in patients who are immunocompromised. Health care facilities are reminded of the importance of systematic implementation of infection prevention and control (IPC). Health care facilities that provide care for patients suspected or confirmed with MERS-CoV infection should take appropriate measures to decrease the risk of transmission of the virus to other patients, health care workers and visitors. All Member States are reminded to promptly assess and notify WHO of any new case of infection with MERS-CoV, along with information about potential exposures that may have resulted in infection and a description of the clinical course. Investigation into the source of exposure should promptly be initiated to identify the mode of exposure, so that further transmission of the virus can be prevented. WHO does not advise special screening at points of entry with regard to this event, nor does it currently recommend the application of any travel or trade restrictions. WHO has convened an Emergency Committee under the International Health Regulations (IHR) in order to be prepared for a change in the situation. The Emergency Committee, which comprises international experts from all WHO Regions, will provide expert technical advice to the WHO Director-General in accordance to the IHR (2005). The 1st meeting of the Committee took place on [9 Jul 2013] and a further meeting is scheduled for next week [week of 15 Jul 2013]. (Emerging Pathogens are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX (MOLDOVA): 09 July 2013, he Ministry of Health of Moldova has reported an outbreak of anthrax in the village of Veden, in Soroca district, located in northeast Moldova close to the border with Ukraine. Results of an epidemiological survey of several inhabitants of the village revealed the 4 patients were infected after a meal in which the main dish was freshly cooked beef. All patients were hospitalized to the Republican Infectious Diseases hospital: one of them is in critical condition and the other 3 are in the moderately severe condition. Specialists of Ministry of Agriculture of Moldova are providing the measures for the localization of the infection to prevent the spread of infection. [Presumably livestock vaccination and destruction of any contaminated meat. - Mod.MHJ] (Anthrax is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (SOUTH AFRICA): 09 July 2013, farmer who has been diagnosed with Crimean-Congo hemorrhagic fever [CCHF], a life-threatening disease, has been admitted to a Pretoria hospital. On Sunday [7 Jul 2013], Dr. Lucille Blumberg, from the National Institute for Communicable Diseases (NICD), confirmed that the man, who is in his 40s, was diagnosed with CCHF. She said the man was transferred from a hospital in Mpumalanga on Friday [5 Jul 2013] before the tests confirmed that he had the disease. Tests had been run while he was still in Mpumalanga because it was suspected he had CCHF. Commenting on the patient's condition, Blumberg said: "He is in a stable condition, and he is improving." Blumberg said the man had a fever, headache, muscle pain and bleeding gums. 3 other cases of CCHF have been reported in South Africa this year [2013] -- one in North West, while the other 2 patients were from the Free State. According to the 1 Jan 2013 communique on the NICD website, a 31-year-old man working as a game warden on a private game ranch near Jagersfontein in the Free State presented with clinical symptoms suggestive CCHF. A 2nd case of CCHF was confirmed on 12 Jan 2013, after a 44-year-old man was taken to hospital in Bloemfontein. He had been on a farm in Pomfret, North West (about 5 km from the Botswana border), where he was bitten by a tick; 3 days later, he developed symptoms and presented with fever, rash, conjunctivitis and pharyngitis. Blumberg said: "They were all doing very well and have long been discharged." (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable